

Assessment Report on the Feasibility of a Roles and Responsibilities Consensus Building Process

Submitted to
The Massachusetts Department of Social Services
and
The Massachusetts Office of Dispute Resolution

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Assessment Report on the Feasibility of a Roles and Responsibilities Consensus Building Process

Executive Summary

This Assessment Report describes the findings and recommendations of William DeVane Logue, the facilitator, regarding a consensus building process to determine public/private case management roles and responsibilities within the broader scope of the System of Care Procurement Review. During October and November 2003, Logue held in-depth meetings with the Department of Social Services (DSS) and conducted over 50 stakeholder interviews with DSS staff, private providers, families and youth around the state. Generous with their time and thoughtful, all the interviewees raised many substantive issues, while expressing their support of the consensus building process.

After careful analysis of the meetings and interviews, Logue concludes that all of the stakeholders show a high motivation to work together to develop mutually agreed upon recommendations on public/private case management roles and responsibilities. He recommends that in February no more than 22 stakeholders be identified and invited to take part in the consensus building process. Participants must not only be knowledgeable about the issues to be discussed but also capable of articulating the interests and perspectives of the categories of stakeholders they represent, not just their own.

The beginning of this process occurred in September 2002 when DSS launched a Procurement Review as one of five key initiatives. The overall goal was the effective use of resources to ensure that services are purchased in a manner that best supports children and their families. The Workgroup recommended that DSS build on and expand its use of lead agencies as partners to develop local integrated service networks. In recommending the use of lead agencies, the Workgroup also recommended that they be held accountable for outcomes to a greater extent than DSS has done in the past. One of the key questions that the Procurement Review Workgroup raised was on the roles and responsibilities within DSS as they relate to those of providers contracted to serve as lead agencies. Given that one of the Workgroup's recommendations was that DSS increase the accountability of providers for outcomes, an essential precursor step was to clarify the scope of decision making authority that DSS was willing to delegate to lead agencies. The Workgroup stated in its final report that responsibility, accountability, and authority must be commensurate.

DSS saw the challenge of clarifying its decision making roles as well as those of its contracted lead agencies as an opportunity to engage in an intensive internal discussion. However, it was also cognizant of the value of having an external perspective. To expand the dialogue and to encourage fresh thinking, DSS explored ways of involving a larger group of stakeholders. With the advice of the Massachusetts Office of Dispute

Resolution, a consensus building process was chosen. A planning group then interviewed several facilitators, choosing William Logue.

The purposes of the interviews that Logue conducted were: to identify relevant stakeholder categories and their concerns; identify key areas of agreement and issues for further discussion; and assess the willingness of key stakeholders to engage in the process in a collaborative manner. Interviewees were asked to respond to the appropriateness of four areas of inquiry to guide the process. They were not asked to answer the questions, because that would be one of the purposes of the consensus building process. The questions concerned the allocation of specific workload tasks, the assignment of service management decision making in relation to the lead agency model, the elimination of redundancies, the assignment of case management between DSS and private providers, and the effect of clarifying public and private roles on the workload of the DSS social workers. The interviews were affected somewhat by limited awareness of the System of Care initiative and the fact that the model has not been fully defined. While System of Care is not part of the mandate of the consensus building process, it will have significant influence, affecting the ability and willingness of the stakeholders to address case roles and responsibilities. Interviewees agreed that the four areas of inquiry are the correct ones. Furthermore, they identified a wide array of substantive issues including the desire for collaborative decision making; the difficulty of measuring outcomes; and the interrelationship of accountability and responsibility.

Logue recommends that in February stakeholders be invited to join the Recommendations Group (RG) comprised of no more than 22 people, of whom five to seven will be providers and the rest DSS staff as well as family representatives. This limited number means that participants must be able to articulate a broad range of interests as well as to think creatively about options. To further extend the lines of communication to the provider community, it is recommended that a Provider Advisory Council be formed to give feedback to the provider participants. Various outreach methods to DSS staff and others will also be instituted. The analytical framework for the discussions will start with an existing case flow outline to identify key decision points. A limited number of fact-based scenarios will then be used to discuss the implications of the System of Care on decision making and roles and responsibilities. As ideas emerge, Logue will draft a document (called a single text) containing those recommendations that have the broadest support.

The recommendations will be presented to the Commissioner of DSS to be used for the Request for Responses (RFR). However, there is also an important secondary benefit: by engaging in a broad participatory process, DSS will increase the level of understanding and support throughout DSS and the provider community. This in turn will improve the prospects for a smooth transition to the new System of Care and Area Based Lead Agency model. Ultimately, it is children and families who will benefit from the thoughtful commitment that DSS and the providers have made to the consensus building process.

I. INTRODUCTION AND BACKGROUND

A. DSS Initiatives and Their Context

In September 2002, DSS began a Procurement Review as one of five key initiatives. The overall goal was to set the stage to use resources effectively and ensure that services are purchased in a manner that best supports children and their families. This effort took place within the larger context of creating a community of practice through implementing Continuous Quality Improvement (CQI), establishing a Professional Development Institute, and designing and testing approaches to team-based practice. In addition, case practice enhancement initiatives included creating a continuum of community-based care, developing better approaches to Children in Need of Service (CHINS), Family Group Conferencing, and strengthening the capacity of DSS to address key risk factors for children, namely family violence, substance abuse and mental illness.

B. System of Care Initiative

A Procurement Review Workgroup was established which was comprised of DSS senior managers, provider agency executive directors, and parents. The 28-member Workgroup made a series of recommendations for designing, managing and purchasing a System of Care. It also developed a “working hypothesis” for the use of lead agencies. DSS’s procurement planning work is further developing this hypothesis, guided by the Workgroup’s recommendations. A System of Care addresses the problem of isolated and segregated purchased services (which make transitions between services difficult for families) by making available an array of services so that families can be helped earlier with better connections to community supports. The goal is smoother transitions and improved outcomes.

The ultimate goals of the System of Care procurement are closely integrated with CQI, the Professional Development Institute, and case practice enhancement initiatives. The goals are to:

- Support and enhance the capability of families to keep safe and nurture their children.
- Increase community tenure by reducing the need and duration for out-of-community placements.
- Ensure that no child enters adulthood alone but has sustained healthy relationships.
- Ensure the most effective and efficient allocation and utilization of public resources possible (including funding, staff, expertise, legal authority, etc.) while achieving positive outcomes for children and families.

- Restore a healthy and appropriate balance of mutual accountability between the public child welfare agency and communities in supporting families in caring for their children.

Framework for the New System of Care

The Department will contract with providers to establish Area Based Lead Agencies and Regional Resource Centers. The general framework and approach were recommended by the Workgroup. Their recommendations address designing, managing, and purchasing services using a system of care approach. The full report is available at <http://www.state.ma.us/dss>.

In the Workgroup recommendations, Area Based Lead Agencies will partner with the Area Office and will focus on enhancing local community service systems of care. They will:

- Participate in case planning teams in order to provide expertise on service availability and to develop individualized services as necessary.
- Facilitate service access and monitor progress towards service plan goals.
- Review utilization of services and recommend changes in service intensity, duration, and termination.
- Develop and manage local service networks that center on community-based programs that address needs identified through the Area Office's CQI work.

Regional Resource Centers will support local systems of care by creating regional markets and purchasing approaches for services that span multiple Area Offices. They will:

- Develop programs to serve special populations that a single Area Office does not serve enough of to purchase its own program.
- Integrate services and funding from other state purchasers.
- Broker services across the Region as needed to support Area Based Leads.

C. Roles and Responsibilities

Relationship of Area Based Lead Agencies and Regional Resource Centers: The recommendations of the Workgroup raised two critical questions. The first was to define the working relationship between the Area Based Lead Agencies and the Regional Resource Centers. This question is central to DSS's procurement planning work but will not be addressed through the consensus building process.

Working Relationship of DSS and Lead Agencies: The second question encompasses the case management roles and responsibilities within DSS itself as they relate to those of

providers contracted to serve as lead agencies. While the discussion about the role of private providers is taken up periodically in the context of a structured procurement process, the role of the public agency is rarely examined explicitly, comprehensively, or in relation to the contracted private providers. The Workgroup raised the question of the public agency role but recognized that it was beyond its purview. However, it identified for DSS the need to clarify the extent to which it would be willing to delegate decision making responsibility and authority to lead agencies given DSS's stated interest in holding leads more accountable for outcomes.

Case Management and Service Management: Case management is not a single task but a complex set of tasks and decisions. Part of case management is service management, which includes decisions about identifying appropriate services, transitioning service intensity, monitoring utilization, and terminating services. DSS social workers do not handle their case management responsibilities solely on their own. They work with and are advised by their supervisors, area program managers (APMs), area directors (ADs), resource coordinators, colleagues, legal staff, managers in Regional and Central Offices, and service providers. What unites these experts is the case plan goal for the family to which they are collectively accountable.

Commonworks is the one program in which DSS has already assigned greater responsibility and authority to providers for some service management decisions. In Commonworks, lead agencies are responsible for transitioning youth to less restrictive levels of care and, ultimately, for supporting their return to families or Departmental foster care. In practice, there is not a consistent view of their scope of authority, resulting in the need to negotiate it at the area level. This results in a duplication of efforts as well as gaps in focus.

Accountability for Outcomes: The Workgroup further recommended that DSS increase the extent to which it holds providers accountable for outcomes. This relates directly to the need for clarification of the scope of decision making authority. The Workgroup recognized that clarification had to be founded on a close look at the various views of casework; philosophy and values; regulation and policy; operational procedures; field reality and daily practice. This would require a broad perspective coupled with a forthright willingness to take on the difficult discussion about authority, responsibility and accountability.

II. ASSESSMENT PHASE OF THE CONSENSUS BUILDING PROCESS

Expanding the Dialogue: DSS saw the Procurement of Services and the design of the System of Care as an opportunity to engage in an intensive internal discussion. However, it was also cognizant of the value of having an external perspective with respect to roles and responsibilities. Therefore, for that portion of the discussion, DSS explored ways of involving a larger group of affected stakeholders in more clearly defining roles and

responsibilities and decision making. With the advice of the Massachusetts Office of Dispute Resolution, a consensus building process was suggested as a means of gaining broader input, generating more creative ideas and assisting DSS in clarifying future roles and responsibilities. (An overview of consensus building is in the Appendix to this report.)

Selection and Role of Facilitator: The Massachusetts Office of Dispute Resolution designed and administered a facilitator selection process for DSS that involved stakeholder representation. A planning group of DSS staff, providers and family representatives was established to interview and select a consultant to manage and facilitate the consensus building process. The planning group selected William Logue to facilitate discussions concerning public/private roles and responsibilities.

During the assessment phase, the facilitator is responsible for analyzing the situation and making recommendations to the Commissioner concerning the issues and the consensus building process. Following the completion of the assessment, the facilitator is responsible for structuring the consensus building process in a fair and equitable way to encourage the broad and deep engagement of all participants.

Cost: DSS, through the Massachusetts Office of Dispute Resolution, has assumed the costs of the assessment and any consensus building process. The facilitator will be under contract to MODR.

Conducting Assessment Interviews: Beginning in late October, the facilitator interviewed more than 50 people individually and in groups. (See the Appendix for the list of interviewees.) They represented a broad array of stakeholders who were identified with the assistance of the planning group. Within DSS, interviews were conducted with social workers, supervisors, resource coordinators, area program managers, area directors, regional staff and directors, regional counsel and central office staff. Interviews were conducted with providers of residential care, therapeutic foster care, and community-based services, lead agencies and representatives of key industry groups. Family advocates were also interviewed, and a meeting was held with the Youth Advisory Council.

The interviews were informal and lasted from 45 minutes to one and one half hours. Interviewees were promised that no individually attributable statements would be made in this report. At the outset they were provided with an overview of the entire process as well as the goals of the interviews as part of the assessment phase. These were to:

- Identify relevant stakeholder categories and their concerns;
- Identify key areas of agreement and issues for further discussion; and
- Assess the willingness of key stakeholders to engage in the process in a collaborative manner.

This report summarizes those issues, suggests general structural options, ground rules, and a plan for proceeding with the consensus building process.

Areas of Inquiry: Four areas of inquiry were identified by DSS to focus the discussions in the consensus building process. Interviewees were asked to respond to the appropriateness of the questions but not to try to answer them. The four areas are:

- 1) The allocation of specific workload tasks within a case. Is there redundancy in the current allocation? If so, how should we decide who does what?
- 2) The assignment of service management related decision making within a case. How well does the Commonworks model work? What changes should be made in light of a desire for increased accountability?
- 3) The assignment of case management between DSS and private providers. What might this look like for particular populations (e.g. CHINS or multi-agency involved kids)?
- 4) Can the design and delineation of the public and private roles reduce the burden on the DSS social worker and have a positive impact on their work with families?

As a result of the interviews, the questions have been modified slightly. They are restated in the Recommendations section of this report.

An Open and Inclusive Approach: Since the arrival of Commissioner Spence in December 2001, openness and inclusiveness have been important features of the entire process of change initiated by DSS. Many Departmental staff members and private providers have been invited to take part and share their ideas. Because this inclusive and open approach is so different from a traditional top-down approach, many people have been uncertain how to react. Instead of viewing it as an opportunity to participate, they see it as an indication that DSS does not have a clear vision yet. In terms of the interviews, this perception prompted some people to focus on the System of Care model instead of case management roles and responsibilities.

Issues Raised in Interviews That Are Related to Other Initiatives: The purpose was to identify interests and issues both directly relating to and having influence on the discussions as they might unfold. Although the consensus building discussions will be designed to focus on case management roles and responsibilities, they will not be held in a vacuum.

In addressing the questions, interviewees identified a wide array of issues and interests that are related to other initiatives but which will impact the consensus building process. The discussions were affected somewhat by the interviewees' limited awareness of the System of Care initiative and the fact that the model has not yet been fully defined. Therefore, most interviewees tended to address design issues related to the System of Care as a means of getting at case management roles and responsibilities. It is clear that

while the System of Care design is not part of the mandate of the consensus building process, it will have significant influence on the process, particularly the ability and willingness of the stakeholders to address case roles and responsibilities. The System of Care design work will occur concurrently with the consensus building process. However, final decisions about design and operations cannot be made until this process develops recommendations about the decision making roles and responsibilities of DSS and its lead agencies. Participants might feel frustrated with the lack of System of Care design details; however, the location of decision making authority must be addressed prior to many other System of Care design questions.

III. SUBSTANTIVE ISSUES IDENTIFIED DURING THE ASSESSMENT

The reader is reminded that this assessment report is a summary of personal perspectives and concerns and does not include all comments. Further, although there are communities of interest such as residential providers or family based service providers (FBS), and large organizations such as DSS, rarely is there a single perspective within these communities. The majority of those interviewed at DSS were area office staff, therefore, the perspectives identified as those of DSS tend to reflect their thoughts.

The first three substantive issues are at the heart of case management roles and responsibilities and decision making. Some of the others are contextual. A few, such as The Changing Need for Residential Care, are being addressed by separate DSS workgroups. However, all the issues are included here for two reasons: they were raised by interviewees, and they may affect the consensus building discussion.

A. Substantive Issues Common to all Stakeholders

1.) The Interrelationship of Accountability and Responsibility

There is a common understanding that DSS would like to share greater responsibility with providers and that providers would like to receive it. All see shared decision making as more effective, creating the potential to relieve stress on social workers and on the system when difficult decisions must be made. However, both DSS and providers expressed concern about the consequences if a child or family member involved with DSS is seriously injured or dies. They expressed great hope that shared decision making would also lead to shared responsibility if such an unfortunate event were to occur. Yet DSS staff was certain that the media and the public would focus on DSS and would demand that they be accountable. To a degree many providers concur.

Many providers agreed they did not have DSS's capacity to handle legal issues. The shadow of the law and the courts—who all deem to be increasingly interventionist in

removing children and making clinically specific decisions—leaves everyone involved feeling that they lack influence over some decisions and uncertain about their ability to make decisions that will stick.

The question of who has ultimate decision making responsibility and veto-power was raised repeatedly. Some DSS staff and many providers felt that the care and protection mandate and the cloak of confidentiality were wielded in an overly broad fashion and used as de facto control and veto mechanisms by DSS.

In regard to the use of the veto, both providers and DSS expressed the need for a dispute resolution process that was rapid, consistent, and procedurally fair.

The four areas of inquiry put to the interviewees use the terms “case management” and “service management,” a distinction few interviewees made. This lack of agreement about what exactly falls under case management and service management raised concerns about the future role of the DSS social worker. As currently defined, service management is considered a subset of case management.

The comfort level of DSS staff in sharing or delegating responsibility with lead agencies is tied to the issue of quality and quantity of provider services and will impact their willingness to engage creatively in the consensus building process about new partnership models and altered roles.

2.) The Challenge of Measuring Outcomes

There was agreement that outcomes and their measurement would play a significant role in the comfort level of shared and delegated decision making. Currently, many *quantitative* and procedural outcome measures are in place. However, several interviewees felt that *qualitative* outcome measures are either weak or non-existent. The setting and examination of outcomes will be done in conjunction with the Department’s Continuous Quality Improvement (CQI) efforts to examine its own internal practice, but which will likely extend to the System of Care. In regard to the case management roles and responsibilities consensus building process, the challenge of measuring outcomes causes DSS line staff to hesitate sharing decision making authority and providers to wonder what they will be accountable for. Lastly concerns were expressed about the potential for additional paperwork related to outcomes and decision making in the System of Care that could detract from service provision. There was hope that an effective automated data collection and reporting system would be developed to address this concern.

Some DSS staff expressed the concern that undue pressure to achieve certain outcomes could result in inappropriate discharges or creaming of acceptances to improve statistical results, although this concern could be addressed by referral criteria and no-right-of-refusal contract terms. Providers are concerned about a quality-by-the-numbers approach and an episode-of-care rate (if under-funded) that could place them at financial risk but

more significantly hurt children. Issues of accountability are compounded by multi-agency involved families where more aspects are outside of the control of DSS and its providers.

3.) Desire to Create Greater Depth of Mutual Understanding

Providers and DSS stated that limited interaction, as well as the youth and inexperience of many DSS social workers and provider staff, lead to an incomplete understanding of the nature and complexity of each other's jobs. The unfortunate consequences are limited levels of trust and questions about competency. However, there is a considerable mutual respect and a general awareness of the difficulties all face in trying to do their jobs. There is a reservoir of goodwill centered on everyone's commitment to improving the lives of children and a willingness to work together.

DSS line staff feel that their protective mandate requires them to make decisions about what is best for a child without the primary concern of money. DSS staff expressed concern that lead agencies, as providers and brokers of services, will be forced to make decisions based on cost of service rather than effective outcomes for children and families. Providers feel that too often DSS is reactive and that children can get stuck in placement for extended periods. These personal perspectives, regardless of their correctness, affect the level of trust, which in turn may affect the level of responsibility that is given to lead agencies.

4.) Desire for Collaborative Case Management Decision Making

A collaborative and team-based approach to decision making is viewed favorably by both DSS line staff and providers because it offers greater potential to assess and match a child or family's needs with the resources available, the result being a better family-based and community-based plan for a child. The team approach when used internally among DSS staff is considered to be a valuable means of enlarging the circle of decision making and sharing responsibility because decisions are made jointly. As a result, the social worker feels supported. Currently, when working collaboratively with providers, most DSS staff sees them in a consultative role with DSS retaining veto power over decision making. This varies by type of service and region. Some frustration exists with the DSS approval process, for example, a decision is reached by consensus at a team meeting, but then the team must wait for approval, with the potential of being overruled by a manager who was not present at a meeting.

The provider community expressed the desire to be involved in collaborative decision making earlier and more frequently so that services and resources can be selected appropriately. They are concerned that the initial assessment without input about available services may result in unnecessary removals and placements. For example, if DSS makes a decision about residential placement without consulting providers about the availability of appropriate community-based services, a viable alternative to residential

placement may be overlooked. There was agreement among providers that many social workers are not sufficiently aware of the community-based resources including informal supports that are available.

Both the provider community and DSS staff believe they each have a more complete perspective of the family situation. Providers working with families believe they have a better overall picture of the situation because they are in regular contact with families receiving services. Therefore, they can bring to the team an in-depth perspective that the social worker may lack. Conversely, DSS sees its purview as broader than that of the providers because DSS must work with the local educational systems, the court system, other state agencies, and may be addressing needs of different family members receiving services from several providers. DSS staff also feels that their training and expertise is often more broad and relates directly to their protective mandate. An example is a community-based substance abuse provider who may be in frequent contact with a child and family but who does not have the specialized training to recognize emerging signs and assess for sexual abuse during their regular provision of services. The question of who has the better perspective leads to differing assumptions about need, authority and competency. This results in tensions and limited depth in the level of collaboration.

5.) Relationship of Lead Agency Design and Roles and Responsibilities

Everyone agreed that the issue of service management and lead agencies is central and that how the lead agency model is structured is directly correlated to case management roles and responsibilities. Issues identified were: 1. the quality and type (for-profit, non-profit, consortiums, etc.) of potential bidders for lead agency; 2. quality assurance, specifically how lead agencies would ensure the quality of provider services; 3. contractual fairness and the necessity for caps on self-referral; 4. and the proposed number of leads. Some providers maintain that there should be fewer leads to achieve economies of scale. Conversely, others maintain too few leads will result in a disconnect between community-based services and children and their families particularly in non-urban areas. DSS is aware of these concerns and is taking them into consideration. They do not pertain directly to the case management roles and responsibilities discussion. The degree of decision making authority delegated to leads must be articulated prior to completing the lead agency design.

DSS has been at the forefront in the use and possible expansion of the lead agency model within its System of Care. Because the Executive Office of Health and Human Services is exploring the use of the model in other state agencies, providers are monitoring closely the evolution of the DSS model. There is concern that this could bring additional political attention or pressure to the System of Care design at DSS.

6.) Regional Variation in Community-Based Resources

There is regional unevenness in depth and quality of community-based resources. The eastern area, especially around metropolitan Boston, is believed to be resource rich in the number and type of providers. However, even there issues arise as to the adequacy of services at the local level, particularly in regard to linguistic and cultural sensitivity for smaller ethnic groups. While the eastern area is seen as providing a wider array of choices, the downside is less cooperation and collaboration among providers. Furthermore, some providers are so small that they are concerned about their ability to make the changes required by the new System of Care.

In much of the western portion of the state, particularly rural areas, the geographic spread of providers and children and their families with the consequent transportation issues are cited as impediments to effective service. (One provider commented that when a rural family needs to “go all over the place to get services,” it increases their stress and can actually make the situation worse.) The limited number of providers leads to limited services but conversely it also leads to greater familiarity with services available and better collaboration among providers in the provision of care to children and families.

DSS line staff was of varied opinion about the depth of informal and natural supports that are a key element of the System of Care. Skepticism was greatest outside of the immediate metropolitan Boston area.

DSS line staff raised the issues of provider wait-lists, gaps in coverage, and unevenness in service. At present, when services are not available, the social worker must function as a service provider and interim stop gap. Currently DSS staff feels that with budget cutbacks at DMH and DMR, court referrals and §51-a filings by schools and others, more cases come their way. DSS is the only agency that is not able to “control the front door.” Once a case is opened, social workers then feel that providers’ contractual boundaries limit the scope and availability of services. The result is that the social workers must shoulder the burden as a last resort, not because it is clinically appropriate. While they are willing to share work and responsibility, they are concerned that providers will not be available when needed, especially after hours or in crisis situations. This may present an opportunity to examine the role of the social worker and lead agencies.

Community-based providers want to make certain that “the local voice be heard,” as one interviewee expressed it. Many are small and are concerned that lead agencies will control the flow of referrals, causing them to either fail or lose their identity through mergers into large lead agencies and networks of organizations. The System of Care presently being developed by DSS has as one of its components locally-based services that are family and community responsive. Smaller community-based providers are concerned that if a lead agency chooses to seek cost savings through economies of scale, the result may be a diminishment of local connections. This issue is tangential to case management roles and responsibilities. However, representatives from community-based providers will be at the consensus building table. It is likely that their perception of case management roles and responsibilities will be tied to the System of Care.

7.) Variation in DSS

Just as there is regional variation in the provider community, there is great regional variation in DSS offices. Some of the variation is due to the needs of a particular area, but some is due to “dominant personalities” and embedded culture that has developed within offices. Providers who work across area and regional offices notice this the most. Both DSS line staff and providers have developed informal mechanisms to cope with variation and to work around weak links within the DSS and provider system.

Most felt that while Department-wide consistency was important, any recommendations, either on the System of Care or case management roles and responsibilities, must be flexible enough to address local circumstances. The level of flexibility while maintaining integrity will be a source of debate.

The history of national shifts in practice, previous change initiatives and pilot programs have left many providers and staff with a “wait and see” attitude about possible changes. This skepticism is balanced with optimism and a desire for change among many other staff. One provider said that DSS middle managers are “powerful holders of culture up and down the line.” Therefore, they are perceived to be essential to successful implementation of all change initiatives.

8.) The Changing Need for Residential Care

Many children in residential placements have more serious problems than in the past; even so, some stay in placements longer than necessary. Too often families and children are forced to “fail up” into residential care. There is broad agreement that even with the increasing emphasis on community-based care, the need for residential services will not go away. Furthermore, there is the perception that DSS is risk-averse and that for the safety of a child, residential placement is seen as the safe decision.

At present, there is no hard data as to how many children are candidates for moving out of residential care to community-based care. In fact, some people maintain that more beds are required, not less, as indicated by wait lists. There is also agreement that there needs to be a smooth transition from residential care to community settings.

The changing need for residential care does not relate directly to case management roles and responsibilities. DSS has convened a separate workgroup with residential providers to generate ideas to help them prepare for the transition of resources from residential to community-based services.

9.) Family-Based Care Uneven Implementation

Family-based care and bringing in the family “at the front” is seen as important by everyone. However, community-based providers believe that DSS’s support is not as deep as it could be. DSS supports the concept of family-based care as one of its core principles, but agrees that some of its offices have been much more pro-active than others. Some line staff fully support family involvement but others feel either intimidated or are convinced that many families no longer have the capacity or desire to address their problems or stay involved in their children’s lives.

Family, foster care, community and residential providers all expressed a desire to bridge and coordinate services and transitions more effectively. Providers, including residential providers, and DSS all agreed that in some situations children could remain in their homes or have shorter out-of-home placements with greater family involvement and support. A number of providers stated that greater family involvement in service planning is more time-consuming and difficult for the social worker although ultimately it is more successful. Under time pressure, sometimes it is easier procedurally for the social worker to begin with a menu of services available than to begin with a need identified by the family.

FBS is not seen as a uniform model across the state due to variability in lead agencies, provider depth, and area office receptivity and culture. Generally the co-location of the FBS lead agency service coordinator and DSS is seen as positive, increasing collaborative decision making and smoothing transitions. There is less satisfaction in more rural offices where FBS does not have sufficient services or geographic reach into the communities where families live. “For us, FBS is not local enough,” said one provider.

These concerns, especially around the provision of collateral services by social workers, will be addressed by the System of Care design. However, it is likely they will be raised in the case management roles and responsibilities discussion.

10.) Inefficiencies and Redundancies Created by Policy and Custom

Providers and DSS agree that there are some inefficiencies and redundancies that can be eliminated particularly around required meetings, paperwork, visitation, and collateral matters. All agreed that children need to be carefully monitored to assure their safety and well-being. Further they agreed that current policies about who and how that was done and the lack of differentiated case management cut into the time a social worker has for effective case practice.

Various aspects of case management and the regulatory process require meetings to assure that children do not drift in the system. However, as these protective regulatory measures have been layered on each other, the scheduling of multiple meetings has become frustratingly difficult. Paradoxically, while providers and DSS staff expressed

great dissatisfaction with the number of meetings and overlapping paperwork, they also expressed support for meetings attended by the right people, because such meetings were more likely to lead to a correct assessment and service selection that would benefit children and their families. There was agreement that while there may well be a need for separate meetings, the process could be reexamined to use everyone's time and resources more efficiently and also that forms could be streamlined.

DSS does a great deal of crisis management. Social workers also have to handle collateral calls and arrangements such as scheduling a doctor's appointment and then finding transportation or providing it themselves. DSS believes that providers are not aware of the time-consuming nature of the collateral efforts including attendance in court. Confusion about responsibility for collateral matters is reflective of lack of full understanding of contractual limitations at the field level.

11.) Transient versus Permanent Change

There is widespread optimism that a real opportunity exists to create meaningful change and improve the system to benefit children and their families. The Commissioner has been clear about his commitment to the change and the reasons behind it. His ability to advocate for the children and families of DSS to maintain needed services and staffing has gained the respect of all involved. The transparency of the planning processes and level of stakeholder engagement have given voice to many who have not felt heard before.

At the same time, there is concern about budgetary and political pressures outside of DSS. Also, there is a long history within DSS of pilots that were never scaled up and new national models proposed but not fully implemented. Swings and periodic policy shifts have left people skeptical, wondering whether this change initiative has been undertaken for economic reasons or is based on research on best practices and outcomes. There was agreement that given the Department's level of commitment, it should implement the changes fully in a way that assures the stable provision of services and smooth transitions for everyone.

Currently, providers are hesitant about the change initiatives because they are concerned that DSS will begin to go forward and then will retrench due to budgetary or other pressures.

B. SUBSTANTIVE ISSUES RAISED BY DSS

1.) DSS Mandate Concerning Protective Cases

Most DSS staff interviewed believe strongly that DSS must handle protective cases and has the legal capability to do so. Many were not clear about the legal limitations (if any) on DSS's ability to delegate case and service management decision making for protective

and non-protective cases. This question will need to be addressed by DSS at the outset of the consensus building process.

2.) Crisis Management

DSS staff, especially line staff, stated that influences outside of their control, including the courts, often created a crisis management situation. As funding has been reduced in other human service programs, more families with needs outside the Department's area of expertise end up with DSS. This is compounded by insufficient knowledge about when it is appropriate to file a protective petition by schools and other mandated reporters. As a result, DSS line staff stated they perform crisis management, including triage, that is avoidable. This has led to an environment where they are pulled in many directions instead of being able to concentrate on offering quality practice to children and their families and selecting the most appropriate services.

3.) Impact of Budgetary Issues and Retirement

The budget stresses of the last two years compounded by early retirements have left some staff tired and feeling under additional pressure. Others are assuming new roles and responsibilities, many on an acting basis. The impact is that two sentiments prevail. One group embraces the possibility of change and sees the timing and opportunity as ripe. This group feels that the system changes should be dramatic instead of a series of small initiatives that may lose momentum. They want to be actively engaged in the dialogue about the future. The other group feels it has seen change come and go. This group is waiting for announcements about what will happen, when it will arrive, and whether it benefits them. At that point, they will go along; in the meantime they will continue to do their jobs as they have been doing.

4.) Keepers of the Culture

Interviewees internal and external to DSS expressed the opinion that many of the longstanding employees, especially supervisors, area program managers and area directors, were the keepers of the culture at DSS. As such, their support of any change initiative is essential to successful implementation. It is also at this level where local custom and practice, leading to departmental variability, is developed and maintained. Familiar with provider and DSS staff strengths and weaknesses, they have learned how to work effectively within and prudently *around* the system

5.) Future Role of Social Workers

Social workers will be in support if the changes are seen as an opportunity to do better work. Social workers do not want to be paper-pushers working at a clinical distance.

Deeply committed, they want to work within a system that enables them to use their skills and expertise to interact effectively with children and their families. Their concerns are that the change initiative will be used to further cut budgets with the potential for layoffs due to privatization.

Most DSS social workers interviewed embraced the concept of shared decision making and teaming within and outside the Department. Virtually all felt that some mechanism could be developed for differentiated case management both by staff experience and by case type. The willingness to move beyond a conceptual discussion relates directly to comfort levels with the competency and accountability of the provider community.

6.) Union

With the recent budgetary struggles, the union has significant concerns about potential layoffs or job loss to privatization. That being said, there is clear recognition that DSS management has worked closely with all staff to keep them involved in decisions. It recognizes that further loss in staff would be detrimental to children and would harm the ability of the Department to fulfill its mission.

Labor welcomes the opportunity to engage in the process with the common understanding that some recommendations and changes in policy and procedures arising out of the process will require negotiation through the collective bargaining process if they are to be implemented.

C. SUBSTANTIVE ISSUES RAISED BY PROVIDERS

1.) Financial Risk

The shift from residential care to community-based care will require adaptation of residential services and expansion of community-based services. With little or no new money in the budget, many people are uncertain about how this will be achieved. This potential shift in funding and landscape has providers from all sectors concerned about financial viability in the interim transition process and the long-term. Providers are concerned that the funding mechanisms of current services are disjointed and inhibit their ability to perform effective work. In a lead agency model with blended capitated rates or episode of care rates, providers worry about decision making and financial risk not in their control.

DSS is fully aware of these concerns about financial risk and is cognizant that the rate structure will need to reflect the degree of decision making responsibility and accountability leads will be delegated. DSS plans to craft contracts appropriately.

2.) Small Community Providers Fear Being Forced Out

Community-based providers typically are smaller organizations with less financial stamina. Interviewees in the group tended to focus on System of Care issues. They are concerned that disruptions in funding and referrals or economies of scale instituted by lead agencies could eliminate small providers. They are aware that the shift from residential to community-based services will require significant changes on their part as well as on the part of residential providers. This may necessitate the provision of 24-7 services and back-up care. However, the smallest providers may not have the capacity to participate in these changes. There is suspicion that the big residential providers will move into community-based care to the detriment of the providers already there. One interviewee said that a “major issue is whether small providers can last during the transition.” Providers are concerned that increased community-based care will require more funding and that there will not be a sufficient allocation of resources for the number of families in care. The concern of small community providers is that DSS will move to larger providers that have a continuity of care. “We are afraid we will get scooped up,” said one provider.

Small providers are uneasy with what they perceive to be a managed care model (similar to the residential component of Commonworks) and what the long-term implications may be.

3.) Potential Reduction of Residential Care

With larger staffs and campus facilities and the consequent overhead, residential providers are trying to anticipate the future. Attuned to national trends, they are aware of the shift to shortened stays and community-based care. Nevertheless, some residential providers intend to maintain their method of business and believe that DSS will continue to need the same level of services and that any shortfalls can be recouped through accepting children from outside of Massachusetts. Others are planning to modify their services to extend into the community and offer their expertise and background in 24/7/365 settings. Although concerned, some believe that they have sufficient financial resources to weather the changes for several years at an institutional level.

D. SUBSTANTIVE ISSUES RAISED BY FOSTER CARE PROVIDERS

Private foster care providers interviewed expressed great hope that the System of Care could create more fluidity in the placement transitions and opportunities for them to lend their expertise, support biological families, and work effectively with other providers. The current categorical nature of services limits discussion and effective care planning.

A number of foster care provider agencies felt that their role was not adequately acknowledged, nor were their contributions valued. They were frustrated with the current decision making methods in which a clinically appropriate decision made by a team

could be vetoed by someone higher up the chain of command, and that no system existed to resolve disputes. They saw role clarification, more timely decision making, and a dispute resolution mechanism as ways to improve overall service to children and families.

E. SUBSTANTIVE ISSUES RAISED BY FAMILY AND YOUTH

Youth and family representatives interviewed expressed some frustration with the involvement in decisions relating to their future often around issues about being informed and feelings that the system did not accord them basic dignity and respect. Too often they find the system confusing. One family representative expressed the hope that the changes which are eventually implemented will make it easier for families to navigate the system.

Some family representatives as well as providers felt that it was often easier to engage families through providers because of mistrust related to the protective mission of DSS. This is based on the perception that DSS becomes involved to remove children. DSS is working to change that perception by placing greater emphasis on family centered values. Although families welcome the idea of being involved in decision making, they also find that it can be a stressful and intimidating experience. Family Group Conferencing and other efforts to involve families and support them in the case planning process have had positive benefits.

IV. PROCEDURAL ISSUES FOR THE CONSENSUS BUILDING PROCESS

There are several interrelated procedural issues that must be weighed and balanced when designing the consensus building process. They are: the development of a common information base, representation and participation, and schedule.

A. Common Information Base

Many interviewees were just learning about the System of Care, the implications for practice, and its relationship to other initiatives. The consensus building process is centered on public/private roles and responsibilities and the implications for decision making and practice that are at the core of the relationship between area offices and Area Based Lead Agencies and Regional Resource Centers. The temptation of the group will be to wander into discussions of the design of the System of Care, training requirements, and quality assurance measures, all of which are being addressed through other departmental initiatives. While some information and ideas are certain to come to light that may be valuable to those initiatives, it will not be the role of the process to delve into these areas.

In order to keep the discussion focused, DSS will have to educate all those involved in the process, at the outset and as circumstances change, about the status of these other initiatives, what parameters are fixed and where contingent recommendations might be appropriate. The coordination with other initiatives and much of the information will need to be assembled in advance from existing sources to save time within the process. This will include legal parameters about duties that cannot be delegated and clarity around what services or case types must be performed or handled by DSS without referral to provider agencies. Other information will need to be gathered as issues arise in the process. Where participants disagree about the validity of information, it may need to be developed jointly in the process to assure its credibility.

B. Representation and Participation

The facilitator identified approximately one dozen stakeholder groups internal to DSS and five broad categories of external stakeholders that should be involved in the process. Many providers and staff raised the importance in case planning of other state agencies, local educational agencies and the courts. Clearly all are important players. However, the consensus building process is designed to address decision making roles and responsibilities among DSS staff and lead agencies. The relationship of DSS to other public agencies will need to be addressed as the design of the System of Care emerges.

Consensus processes are most effective when the full array of interests is able to be articulated for both the broad and narrow interests of stakeholder groups as they relate to the issues under discussion. At this time, there is no conflict that has caused stakeholders to coalesce around particular positions, which is a positive sign. However, most stakeholder categories are not formed into organized groups capable of expressing the wider interests of that group in a way that could be truly representative with decision making capacity to bind or even influence the group as a whole. This is due in part to the geographic diversity of the state, the multitude of service providers, and the nature of the jobs performed by DSS employees; nor do many relationships exist among or across external stakeholder groups.

Within DSS, with the exception of organized labor representatives, there are no formal representative structures. In addition, as mentioned above, several middle managers are new to their positions or are serving in an acting capacity.

Existing associations of providers speak only for portions of the provider community. Other groups, such as Commonworks and FBS lead agencies, would not be seen as representative of the broader underlying interests of the residential and family-based provider communities.

In most consensus building situations, the appropriate course of action is for the facilitator to assist the stakeholder groups in advance of the process with the aim of gaining the capacity to select appropriate representatives. In addition, it is the Department's goal to have broader and more creative input as it examines changes in the

role of its staff. Therefore, the purpose of participation by non-Department stakeholders is to assist in moving the internal discussion forward. The recommendations below are made with this consideration in mind.

C. Schedule and Meeting Locations

The contracts that will begin implementation of the System of Care are to take effect January 2005. To meet this deadline, DSS contemplates issuing the Request for Responses (RFR) in the spring of 2004. An aggressive schedule will need to be maintained in order to arrive at recommendations to be circulated for comment in advance of the issuance of the RFR.

During January, the facilitator will examine methods of expediting the gathering of background information and planning the process to address this tight timeframe. DSS is encouraged to examine the schedule and the relationship to other initiatives to determine where flexibility exists and where work of multiple groups may be coordinated to avoid duplication of efforts and unnecessary delays. The facilitator believes that with careful planning and priority attention from DSS senior staff, there is a reasonable chance of completing the process between January and April 2004.

A central off-site location should be found to accommodate the meetings and avoid distractions inherent in DSS offices.

V. RECOMMENDATIONS

There is strong support inside and outside DSS for proceeding with the consensus building process. On the basis of the information in this assessment report, the facilitator recommends that the process go forward.

A. Broad Participatory Process

The self-examination and changes associated with the System of Care are extraordinarily complex. For the initiatives to be successfully implemented, they will need the support of staff at all levels of the Department and from the provider community. Were DSS to use traditional methods of designing the System of Care and redefining roles and responsibilities and decision making without extensive internal and external consultation, there is a high likelihood that significant delays and other objections might arise. These typically would occur through traditional political channels and collective bargaining processes.

During the past two years, DSS has engaged in a creative process to bring about changes involving a wide range of players. This has set the stage for change. The issue of roles

and responsibilities and decision making is at the center of a successful System of Care. The participants to the process bring their knowledge and expertise about the substance of the issues under discussion. With appropriate stakeholders involved in designing creative and workable solutions, they are more likely to support the implementation of those solutions, bringing greater clarity to roles and responsibilities in the RFR. Through engaging in broad participatory processes, DSS not only lessens the possibility of conflict but also has a wider range of stakeholders prepared to respond to and review the RFR and a head start on preparing internal and external stakeholders for the changes that will occur as the contracts go into effect in January 2005. Although the facilitator believes that there is a high likelihood of success that viable recommendations may be developed by the Recommendations Group, there is the possibility that the group will not reach agreement, especially given the complexity of the issues and the timeframe involved. If this were to occur, the Commissioner would nonetheless benefit from the issues being more clearly crystallized and the impact of a unilateral decision being more fully understood.

There are several important dynamics that flow from the substantive and procedural issues identified above. The evolution of other initiatives and System of Care design will seep into the conversation on roles and responsibilities. There may be some resistance and difficulty imagining a different future reality due to feelings about the capacity for change necessary to implement the vision. There are strong feelings about differences based on geography and what that means about roles and capabilities. All parties are optimistic about the potential for a better future because they see much that can be improved; nonetheless they are concerned that change could threaten their livelihood or challenge their practice philosophy.

B. The Four Areas of Inquiry

The interviewees believed that the areas of inquiry articulated by DSS are a sensible approach for addressing roles and responsibilities. It is significant that not one interviewee considered the questions to be the wrong ones.

Some suggested minor changes in wording especially with respect to the question addressing the Commonworks model. Further, almost all preferred a reordering of the questions; interviewees were split between #4 (the role of the social worker) and #2 (assignment of service management) as the first to be addressed in the consensus building process. But there was strong agreement that the questions, in whatever order, would positively direct the content of the consensus building process.

Revised and reordered, the questions read:

- Can the design and delineation of the public and private decision making roles reduce the burden on the DSS social worker and have a positive impact on their work with families?

- With respect to the assignment of service management related decision making within a case, what can be learned from current lead agency models, such as Commonworks and FBS? What changes could be made in light of a desire for increased accountability?
- Is there redundancy in the current allocation of specific workload tasks within a case? If so, how should we decide who does what?
- What might the assignment of case management between DSS and private providers look like for particular populations (e.g. CHINS or multi-agency involved kids)?

The consensus building group will need to discuss the order of the questions, the appropriateness of the phrasing, and whether there are missing elements to be addressed, bearing in mind the many levels of delegation and the different populations served.

C. Framework of the Consensus Building Process

The diffuseness of many stakeholder groups, the timeframe, and the existence of other related and parallel initiatives will require that the discussions be structured and carefully focused with opportunities for education and feedback from a wider group of stakeholders than those at the table. The following recommendations have been arrived at with the input of the interviewees and DSS. The process design will be further refined during January. (See the process map.)

The majority of interviewees were unable to articulate an analytical framework for addressing the issues in a way that would be creative and take full advantage of the potential for redefined roles and responsibilities in the new System of Care. Such a framework must be respectful of history while not being bound by existing modes of practice.

Drawing from the variety of comments and other simultaneous efforts, it is recommended that the discussions use the following framework. An existing case flow outline will be used to identify key decision points where children and families have reason to interact or receive services from DSS and its providers. A limited number of fact-based scenarios describing typical situations will be used to discuss the implications of the System of Care on roles and responsibilities and decision making. The facilitator will work with DSS staff in January to develop and test these scenarios and to gather statistical and background information necessary to start the process.

D. Stakeholders

1.) Characteristics

The commitment and creativity of stakeholder representatives will be central to the success of the process. Stakeholder representatives should have the following characteristics:

- Be capable of articulating interests and perspectives for the categories of stakeholders they represent, not just their own;
- Be familiar with current clinical roles, responsibilities and decision making;
- Have the trust and respect of the members of their community of interest;
- Have the ability to take the time to participate in the process and to communicate with others in their stakeholder community;
- Represent or have an understanding of linguistic, cultural and geographic diversity; and
- Be willing to engage in the discussion in a collaborative and constructive manner within an agreed upon framework.

2.) Size of Recommendations Group

A representative group of stakeholders will be formed into the Recommendations Group (RG). Because a large group will make management of the discussion more time-intensive (compounded by the fact that some people may be involved in other ongoing initiatives in addition to their regular work), the recommendation is to limit the size to 22 people or under. The cap of 22 decreases the diversity of perspectives at the table, but it has the benefit of encouraging deeper discussions and the development of relationships, which in turn will improve the likelihood of a successful outcome.

It is recommended that DSS identify between 14 and 17 individuals from the Department as well as family representatives for biological and foster families to participate in the process. They should be drawn from the following categories and may include others: social workers, supervisors, area program managers, resource coordinators, area directors, regional directors, mental health specialists, CAP (Collaborative Assessment Program), union, and executive staff. The product of the process will be recommendations to the Commissioner for inclusion in the RFR. The Commissioner will play a central role in the January DSS forums (discussed below) and will participate in several key stages of the consensus building process.

The preferred method of selecting providers to participate would be to have stakeholder groups identify their own representatives. However, the timeframe, the diffuse nature of provider organizations and other constraints make this less critical if other opportunities for feedback are employed. The Recommendations Group will include five to eight

representatives of the provider community invited by DSS with the assistance of the facilitator.

3.) Providers Advisory Council and Other Outreach Methods

Because of the limited number of providers on the RG, it is recommended that a Providers Advisory Council (PAC) be established which provider RG members can keep apprised of the process, and from whom they can receive additional input and feedback. The PAC could be as large as an additional 25 members. In January, the facilitator and DSS will meet with the leadership of provider associations to identify potential PAC members and processes for self-nomination.

The formation of the PAC will be combined with other outreach mechanisms to inform and educate as well as to gather feedback from DSS staff, providers, youth and families. This may include posting information and drafts on the DSS website, forming focus groups, and presentations. Communication will also occur with other workgroups in the System of Care design.

E. Stakeholder Development

The initial phases of the consensus building process will start on two separate tracks, one internal to DSS and the other external. Each will be designed to reach out to a broader group of stakeholders and will set the stage for meetings by the full RG.

The internal track will be more extensive. In January, DSS will start a broad process internally with regional forums lead by the Commissioner and assisted by the facilitator. There will be several goals. Firstly, the forums will provide staff with a deeper understanding of the System of Care. Secondly, they will help staff begin to articulate their values, philosophy and identify the DSS role and contribution as a public child welfare protective agency. Thirdly, they will clarify the unique competencies and strengths of DSS and its partners. This will begin to engage staff throughout DSS in a dialogue examining roles and responsibilities. The forums will also be used to help identify possible members of the RG as representatives for DSS.

The external track will be comprised of meeting with representatives of the provider community to identify RG members and PAC members and to discuss the input process.

F. Consensus Building Meetings

After the stakeholder development meetings, the RG will meet. At the initial meeting the members will receive an overview of the process, discuss their roles, the role of the facilitator, assignments and work agendas. Ground rules for participants and any

alternates or observers will be discussed and agreed upon. The facilitator will propose ground rules for consideration. Typical ground rules for participation address:

- Purpose of the group;
- Roles of members, alternates, observers and facilitator;
- Primary responsibilities (attendance, preparation, participation);
- Rules for decision making (group's definition of consensus);
- Roles of subsidiary workgroups;
- Communication among group members and with other stakeholders; and
- Dealing with the media.

RG members will then be updated on the status of the design of the System of Care and other concurrent initiatives and statutory or other limitations and constraints to changes in roles and responsibilities. A brief workshop will be held on negotiation and consensus building. At the meeting, stakeholders will begin to articulate their interests.

At subsequent meetings, the RG will:

- Confirm and discuss the case flow framework and identify additional information needs;
- Discuss the System of Care and the impact on roles and responsibilities from their perspective and tying them to their interests;
- Confirm criteria to assess options that will meet the maximum interests of all parties;
- Review and confirm the focusing questions;
- Review the scenarios;
- Decide on a workgroup structure, if any;
- Using the scenarios, develop mutually agreeable options and chart public/private roles and responsibilities and decision making; and
- Discuss and decide upon recommendations concerning future roles and responsibilities noting any contingencies.

During several stages, members will seek the advice of and input from a wider array of stakeholders. This may include the PAC, other provider gatherings and focus groups, and groups of DSS staff. This will effectively enlarge the circle of influence and knowledge of the discussions within the process. Various outreach efforts are most likely to occur at certain stages in the process, i.e. before finalizing criteria, options, and recommendations.

The consensus building discussion will move beyond vague suggestions to clear delineation of roles and responsibilities and shared decision making. As options are emerging in the process and a variety are on the table for discussion, the facilitator will draft a document containing the recommendations believed to have the broadest support and noting where further discussion is necessary. This document, often referred to as a "single text," will go through successive iterations. Although there is some risk associated with an early drafting of the document in that it may foreclose some discussion, its purpose is to focus the discussions and allow stakeholders sufficient time to consider

implications in a timely fashion before a final set of recommendations is agreed upon. A report summarizing the process and any final recommendations will be delivered to the Commissioner.

G. Conclusion

After completing this assessment, the facilitator concludes that the internal and external stakeholders are highly motivated to work together to develop mutually agreed upon recommendations on public/private case management roles and responsibilities and decision making. He believes that there is a high likelihood that agreement can be reached through the consensus building process even though the timeframe is tight and the issues are complex.

The consensus building process will be structured in a fair and equitable way to encourage the broad and deep engagement of all participants. The establishment of the PAC and various other outreach mechanisms will extend the lines of communication throughout the provider community and DSS, thereby helping to ensure that the process is both inclusive and transparent.

Recommendations will be presented to the Commissioner of DSS to be used for the RFR. However, there is also an important secondary benefit: by engaging in a broad participatory process, DSS will increase the level of understanding and support throughout DSS and the provider community. This in turn will improve the prospects for a smooth transition to the new System of Care and Area Based Lead Agency model. Ultimately, it is children and families who will benefit from the thoughtful care and commitment that DSS and the providers have invested in the consensus building process.

Interviews

The following people were interviewed individually and in groups as part of the assessment. Most were interviewed in person, some were interviewed by telephone.

Department of Social Services Staff

Social Workers

Karenbeth Griffiths, Whitinsville Area Office

Laurie Cyphers, Chelsea Area Office

Maria D'Addieco, Community Involvement, Community Circle Meetings Chelsea Area Office

Kelly Knight, Springfield Area Office

Julie Maynard, PAC grant project Chelsea Area Office

Megan McConnell, Siblings Project Chelsea Area Office

DSS Supervisors

Celia Barbosa, Whitinsville Area Office

William How, Framingham Area Office

Nancy Ray, Chelsea Area Office

Jill Shaw, Springfield Area Office

Area Program Managers & Resource Coordinators

Louise Brown, Whitinsville Area Office

Kevin Carroll, Framingham Area Office

Area Directors

Connie Contarino, Whitinsville Area Office

Ruth McDermott, Chelsea Area Office

Regional Office Staff

Jennifer Coupe, Springfield Regional Office

Eleanor Dowd, retired Metro Regional Director

Paul Fitzsimmons, Acting Western Regional Director

Tom Malone, Metro Regional Counsel

John Renzi, Boston Regional Program Manager

Debbie Sicilia, DSS Western Region

Sal Scibelli, DSS Western Regional Administrative Manager

Central Office Staff

Fran Carbone, Associate Director of Residential & Adolescent Services

Brian Cummings, Family Support Team Manager

Ellen Finnegan, Director of Finance

Susan Getman, Deputy Commissioner for Field Operations

Susan Maciolek, System of Care Procurement Project Manager

Neal Michaels, Director of Family Based Services

Harry Spence, Commissioner
Pam Whitney, Director Planning and Program Development
Isa Woldegiorgis, Manager of Domestic Violence Specialists

Others

Kimberly Ferrecchia, Mental Health Specialist, Western and Central Regions
Diane Harrold, Boston Region CAP Program
Edward Malloy, Supervisor, representative for SEIU Local 509
Youth Advisory Council members

Family Representatives

Viola Green, Patch Coordinator, Athol
Mindy Mazur, PPAL

Community, Family Based Services and Residential Providers

Susan Ayers, Executive Director, Cambridge Youth Guidance Center
Carolyn Burns, Executive Director, Berkshire Center for Families and Children
Paul Carey, Program Manager, You, Inc.
Borja Alvarez de Toledo, Director of Mental Health Services, Cambridge Youth Guidance Center
Kathleen Hardie, Executive Director, Valuing Our Children
Donna James, Program Director, Gandara Mental Health
Jan Nisenbaum, Executive Director, Commonworks Service Center
Andy Pond, Program Manager, JRI
Jestina Richardson, Executive Director, United Homes
Rick Small, Executive Director, The Walker Home and School
Susan Wayne, Executive Director, JRI

Contracted Foster Care

Tom Borden, Berkshire Center for Families & Children, Program Manager
Vijay Dalal, DARE Director
Ron Hokanson, DARE Clinical Supervisor
Jim Kellner, DARE Intake Coordinator
Susan Mattire, Director Mentor
Barbara Pillarcik, Specialized Home Care Director
Maria D. Rodriguez, TCYP, Director
Wendy Rua, Devereaux Therapeutic Foster Care, Assistant Regional Manager

Others

Katherine Grimes, MSPHY Project, Medical Director

Provider Associations

Barbara Talkov, Executive Director, Children's League of Massachusetts
Michael Weekes, Executive Director, Massachusetts Council of Human Service Providers

Consensus Building – An Overview

William DeVane Logue

[This overview addresses a wide variety of potential processes and situations. The consensus building process for DSS around public/private roles and responsibilities has yet to be fully designed. The outcome from the process will be non-binding; the group will make recommendations within the context of the larger System of Care design process.]

Consensus building is a process that helps groups reach agreements and resolve issues in a manner that respects the interests of all participants. Through the process, a group of stakeholders — those with an interest in the outcome — jointly identify their interests, develop potential solutions and attempt to reach agreement. With all the affected parties involved in the process, stakeholders are able to express their concerns while learning about the needs and concerns of others. The goal is to reach more creative and widely supported agreements than might otherwise be arrived at through traditional “decide and announce,” top down, or voting procedures. Experience has shown that when the stakeholders are involved in designing solutions, they are more likely to support the implementation of those solutions and that the solutions are more creative and workable. The participants to the process bring their knowledge and expertise about the substance of the issues under discussion and are usually assisted by a facilitator or mediator who is expert in managing the process and who keeps a record of the proceedings.

In the public policy arena, a governmental organization or other interested group of stakeholders often convenes the process and brings an initial group together to explore the concept of consensus building. The convener usually sponsors the process and may provide funding for it. The convener may form an ad hoc group of stakeholders to begin to identify the issues and the type of expertise needed from a facilitator. This ad hoc representative group may interview and select the individual or group to assist them with the process.

Once a facilitator or mediator has been engaged, an assessment is conducted to determine if the process is feasible and how to proceed. In this phase, the facilitator interviews stakeholders and gathers information about their interests, including the significant issues, potential obstacles and areas of agreement. It is not unusual for 20 or more interviews to be conducted during this assessment phase. If the issues are amenable to a consensus building process, the assessor makes recommendations about the goals, who should participate, suggests ground rules, summarizes the findings from the assessment and notes whether the outcome will be binding or a set of recommendations to a decision making authority such as an executive agency or legislature.

After the assessment, representative stakeholders are identified (often by their interest groups) and invited to participate. At the early stages, the role of the facilitator is clarified, agendas set, ground rules established, and rules for observers and other logistical issues are addressed and agreed upon. It is at the next stage that consensus building becomes noticeably different from traditional forms of negotiation. Using a problem-solving approach, the principles of interest-based negotiation are applied. The facilitator assists the stakeholders to be constructive in the negotiations by focusing on interests, active listening, and depersonalizing the dialogue or “separating the people from the problem.”

The participants explore and understand each stakeholder group’s interests and the issues. The stakeholders educate each other and jointly develop information so that all can trust its origins and interpretations. Frequently subcommittees or workgroups break off to address specific topics. Occasionally expert advisers assist with technical and fact-finding tasks. As the stakeholders explore options, they create value by seeking options that offer mutual gain — essentially

enlarging the pie. At this stage, they develop criteria to assess options and avoid committing to specific options.

Next the parties express preferences for options and packages of options. These options are evaluated to determine how well they meet the interests of all parties. Agreements are produced in a variety of ways depending on the situation. Sometimes the facilitator develops an early draft agreement, or a single-text, of the initial proposals to focus discussion and as a means of generating additional ideas. This helps stakeholders gain a sense of the magnitude of agreement and they work through successive drafts to finalize agreement. At other times, the parties will develop and discuss the various options and work on the various parts. In this situation they wait until there is a high level agreement before a draft is produced.

The facilitator helps them work toward unanimity if that is possible. Efforts are made to address the interests of those who are uncomfortable and are withholding support and to resolve or incorporate their concerns. Throughout the process, representative stakeholders are expected to keep their constituencies apprised of the negotiations.

For situations where unanimous support is not achieved, the stakeholder participants may have set in advance a percentage of support to constitute the endorsement of the group. An example of this might be a super majority of two-thirds or three-quarters supporting the agreement.

Once the consensus building group has reached the last stage before final agreement and participants have stated their personal support of the accord with the promise to work towards its implementation, they seek the final input and support of their groups. This can be done through focus groups, stakeholder informational meetings, or town hall-like forums with representative stakeholder groups.

Final changes are made and the agreement is implemented or recommendations are delivered to the decision-maker. Where the agreement is binding, monitoring mechanisms are often included, as are methods for reopening discussions should additional issues or implementation difficulties arise. Where recommendations that are not binding are being delivered, the decision-maker takes them into strong consideration within the context of the larger decisions being made. In this situation, the consensus building process has provided the stakeholders with an opportunity to speak with a clear voice and at an earlier stage than is usually available to them. The end result is generally an agreement with broad support and a greater understanding and respect by the stakeholders of both their common interests and the richness of their diversity.

William DeVane Logue, J.D., of the Logue Group based in West Hartford, Connecticut, specializes in conflict resolution and assisted decision making. With 17 years of mediation and facilitation experience, he works with clients in the public and private sectors to creatively craft agreements to build relationships and promote practical solutions to difficult problems. He has served as a consultant to foundations on many social and human service issues and has conducted research on consensus building and collaboration.